YORK CENTRAL SCHOOL
STAFF ACCIDENT REPORT OF WORK-RELATED ACCIDENTS

FILE _____ C-2 _____

INJURED PERSON

INJURED EMPLOYEE (First, M.I., Last)				
ADDRESS (Includes No. & Street, City, State, Zip & Apt. No.)				
DATE OF ACCIDENT	**EMPLOYEE'S S.S. #**	**SEX**	**AGE**	**DATE OF BIRTH**
OCCUPATION (Specific job title at which employed)				
INJURED PERSON PHONE NUMBER-DAYS:		**INJURED PERSON PHONE NUMBER-EVENINGS:**		
PART OR FULL TIME EMPLOYEE?		**EMPLOYEE'S WORK WEEK (Indicate days of week usually worked)**		

ACCIDENT

ADDRESS WHERE ACCIDENT OCCURRED	DEPT WHERE REGULARLY EMPLOYED
TIME OF ACCIDENT _____ ☐ AM ☐ PM / **COUNTY**	**WAS ACCIDENT ON EMPLOYER'S PREMISES?** ☐ YES ☐ NO
DATE STOPPED WORK BECAUSE OF INJURY	**NUMBER OF DAYS LOST**

NATURE OF INJURY

NATURE OF INJURY AND PART(S) OF BODY AFFECTED INCLUDE RIGHT OR LEFT IF APPROPRIATE	DID YOU PROVIDE MEDICAL CARE?	IF YES, WHEN?
WAS INJURED INSTRUCTED TO GO TO THE DOCTOR? ☐ YES ☐ NO	**IF SEEN BY DOCTOR, WHAT DATE?**	
NAME AND ADDRESS OF DOCTOR	**NAME AND ADDRESS OF HOSPITAL**	
HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO	**IF YES, GIVE DATE**	**ANY RESTRICTIONS?** ☐ YES ☐ NO

CAUSE OF ACCIDENT

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific, identify tools, equip or material the employee was using).

HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury. Tell what happened and how it happened. Use back of this sheet if necessary).

PREPARATION

NAMES OF THOSE PRESENT AT TIME OF ACCIDENT	
ADDITIONAL INFORMATION (First aid administered, where taken after accident, etc.)	
SUPERVISOR'S SIGNATURE	**INJURED EMPLOYEE'S SIGNATURE**
PERSON MAKING REPORT (print)	**SIGNATURE OF PERSON MAKING REPORT**
SCHOOL NURSE SIGNATURE	**DATE 1ST KNEW OF INJURY** / **DATE OF THIS REPORT**

Staff Accident Report original 3/04

Date Rec'd in Business Office _____